Original Article

A Comparative Study of Health Status and Quality of Life of Elderly People Living in Old Age Homes and within Family Setup in Raigad District, Maharashtra

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Abstract

Background: The traditional concept of family in India to provide support to the elderly is changing soon with disintegration of joint families. In this scenario the concept of old age homes (OAHs) is gaining momentum and the number of people seeking OAH care is rapidly increasing. However, not much is known about the quality of life (QOL) of Indian elderly staying in the OAH setup. **Objectives:** To assess and compare the Health status, Quality of Life and Depression in elderly people living in OAHs & within family using WHOQOL –OLD questionnaire & Geriatric Depression Scale **Methods:** A cross sectional study was conducted in elderly aged above 60 years of age. After taking a written consent and matching for age and sex & socioeconomic status, 60 elderly from OAHs & 120 elderly living within family setup were selected randomly. The WHOQOL-OLD standard questionnaire & GDS were used to assess quality of life & depression in elderly. **Result:** The QOL of elderly in domains of autonomy, past present & future activities, social participation and intimacy was better in family setup (60.62, 70.62, 66.14 and 58.43) as compared to OAHs (51.35, 62.91, 59.47and 41.16) ($p<0.05$). There was statistically significant difference in mean geriatric depression scores of both the group (3.96 within family setup and 5.76 in OAH's). **Conclusion:** Quality of life of elderly within family setup was better as compared to elderly in OAHs.

Keywords: GDS, Old Age Home, Quality of Life, WHOQOL- old

Introduction

India is the second largest population of the elderly (60+) in the world.[1] With the increase in life expectancy, the size of the geriatric population in India has gone from 20 million in 1951–100 million (8.3%) in 2014 and the number will rise to approximately 130 million by 2021.[2] The conventional concept of family in India, which was to provide support to the elderly, is changing soon with urbanization; modernization, the disintegration of joint family structures into nuclear ones and the changing role of women. Thus, older people have become more vulnerable. Their vulnerability lies mainly in lack of employment, financial insecurity, ill health, and neglect by society.[3] To add to this, misery 45% of aged Indians have chronic diseases and disabilities.[4] The lack of family support made elderly resort to old age homes (OAHs) run by private or voluntary organization for their care and support. In this scenario the concept of OAHs is gaining momentum, and the number of people seeking institutionalization is rapidly increasing. However, not much is known about the response of its residents to institutionalization and its impact on their physical and mental health. Hence, the present study was conducted to assess the health status and QOL of elderly in OAHs as compared to elderly within family setup.

Objectives

1. To assess the health status, morbidity pattern, and living conditions of elderly people living in OAHs and within family setup

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2. To compare quality of life (QOL) of elderly people living in OAHs and those living within family setup, by using the World Health Organization QOL assessment Quality of Life Assessment OLD (WHOQOL–OLD) questionnaire.

3. To assess the prevalence of depression in both the groups using the geriatric depression scale (GDS) 15 Short Form.

Materials and Methods

After obtaining permission from Institutional Ethics Committee, a cross sectional descriptive study was conducted, during the period from January 2015, to July 2015, on elderly people living in two different settings as follows: (a) Those living in OAHs and (b) Those living with their families. Out of three OAHs situated in Panvel, Raigad District, two were selected randomly by lottery method. Thus, a total of 60 consenting elderly from OAHs were interviewed. About 120 elderly from family setup (sample size of 1:2) were selected randomly by the door to door visits in the area surrounding these OAHs and were approximately matched for age, sex, and socioeconomic condition. Matching was made to ensure both the groups are similar and thus eliminate sociodemographic confounding factors which may also affect the QOL. Elderly in the age group of 60–90 years and willing to participate were included in the study. Elderly, who were bedridden, severely ill, audio-visually handicapped or cognitively impaired were excluded from the study. For study purpose, we decided that a minimum of 6 months experience at OAHs would be required to give an unbiased opinion on living conditions of OAHs. Thus, those living in the OAH for <6 months were excluded from the study. Informed written consent was obtained from the study participants after explaining the aims and objectives of the study.

WHOQOL-OLD Module standard questionnaire was used to assess QOL in elderly. The WHOQOL-OLD was developed from the parent instrument: WHOQOL Group's WHOQOL-100. It is a multidimensional measure of QOL and comprises of six domains (24 items): sensory abilities, autonomy, past present and future activities, social participation, death and dying, and intimacy (4 items per domain). Items are scored with the reverse coding of positive responses so that higher scores equal higher QOL; the authors define the scale ranges as 24 (lowest possible QOL) to 120 (highest possible QOL). Response scales are all 5-points.[5-7] A predesigned and prestructured questionnaire was used to evaluate sociodemographic characteristics, morbidity pattern and living condition in OAHs and attitude toward life. The results so obtained were compared between both the groups.

GDS Short Form is designed and validated by Yesavage *et al*., specifically for rating depression in the elderly was used to assess the presence of depression.[8-10] A score of 0–5 is normal. A score >5 suggests depression. Elderly were interviewed in regional language Marathi by the research investigator. Data thus collected was analyzed by SPSS 20 (SPSS company Bangalore, India). Appropriate tests were used for comparison between two groups. The value of $P = 0.05$ was considered as statistically significant.

Result

In OAHs >45% of the elderly were in the age group of above 80 years and 63.30% elderly were widowed. There was no statistically significant difference observed between elderly in both groups in terms of age, sex, and financial dependency. In the OAHs, about 31.67% elderly reported that they had suffered domestic violence/verbal abuse, not satisfied with food (16.67%), and not able to pursue hobbies (21.67%). The overall living condition in the OAHs was different from the living condition of elderly in family setting ($P < 0.05$) [Table 1].

Majority of elderly were suffering from hypertension (46.67%, 58.33%), joint pain (43.33, 33.33%) hearing impairment (40.0%, 23.33%), and diabetes mellitus (6.67%, 33.33%) in OAHs and

Table 1: Sociodemographic profile and living condition of elderly people

Characteristics	Old age home ($n=60$) *n* (%)	Elderly living with family ($n=120$) *n* (%)	*P*
Age group (years)			
60-69	14 (23.3)	26 (21.7)	>0.05
70-79	18 (30.0)	52 (43.3)	
80 and above	28 (46.7)	42 (35.0)	
Sex			
Male	25 (41.7)	54 (48.3)	>0.05
Female	35 (58.3)	66 (51.7)	
Education			
Illiterate and primary	5 (8.3)	19 (15.8)	>0.05
Secondary	17 (28.3)	26 (21.7)	
High school	19 (31.7)	24 (20.0)	
Graduation and above	19 (31.7)	51 (42.5)	
Marital status			
Married	8 (13.3)	78 (65.0)	<0.05
Unmarried	12 (20.0)	12 (10.0)	
Divorced/separated	2 (3.3)	0	
widowed	38 (63.4)	30 (25)	
Family type			
Joint	18 (30.0)	54 (45.0)	<0.05
Nuclear	19 (31.7)	10 (8.30)	
Living with spouse	9 (15.0)	40 (33.4)	
Living alone	14 (23.3)	16 (13.3)	
Financial status			
Dependant	17 (28.3)	44 (36.6)	>0.05
Independent	43 (71.7)	76 (63.4)	
Living condition*			
Insecure	7 (11.6)	16 (13.3)	<0.05
Unhappy with food	10 (16.6)	8 (6.6)	
Can't pursue hobbies	13 (21.6)	8 (6.6)	
Domestic violence/abuse	19 (31.6)	12 (10.0)	
Psycho-social views *			
Neglected by family	26 (43.3)	52 (43.3)	>0.05
Old age has adversely affected life	35 (58.3)	90 (75.0)	

*Multiple responses

within family setup, respectively. It was observed that Diabetes Mellitus, hearing impairment, and difficulty in sleeping were more common problems among elderly staying in OAHs as compared to those staying within family setup.

The total WHOQOL-old score was 59.42 in the elderly staying in OAHs and 64.41 in elderly staying within family setup ($P > 0.05$). The WHOQOL domain scores in terms of autonomy, past present and future activities, social participation and intimacy were comparatively more (60.62, 70.62, 66.14, and 58.43) in the elderly staying with family than those staying in OAHs (51.35, 62.91, 59.47, and 41.16). The differences between mean scores of two groups were statistically significant [Table 2]. In WHOQOL domain Death and Dying, the mean score was higher (70.41) in elderly people staying in OAHs than in elderly people staying with their family (54.79). The difference between mean score was statistically significant ($P < 0.001$). The GDS mean score was significantly more ($P < 0.001$) in OAHs (5.76) than within family (3.96).

Discussion

So far, the health policies in India have focused mainly on maternal and child health, and very few polices exist for the support of elderly. There is a need for greater involvement of the government in geriatric care. More than half of the residents of OAHs in our study were above 75 years and widowed. Similar results were found in the studies conducted in OAHs in Ranchi by Panday *et al*. and Chandrika *et al*.[11,12] Thus, the elderly may have resorted to OAHs as they had no one to look after them at home after the death of their spouses.

In India, there is lesser awareness about the special needs of elderly and caretakers are yet to understand the basis of elderly care (physical, mental, psychological, and social support).[12] The study showed that the overall QOL of elderly staying within the family (64.41) is better than the elderly staying in OAHs (59.42). However, the result is not statistically significant; similar to the result found in the study conducted in Vishakhapatnam city.[12] The QOL in the family setup is significantly better in four out of six domains of the questionnaire. These domains assessed the ability to live independently and take decisions, satisfaction with life and having things to look forward to, ability to participate socially, and have intimate relationships. This difference may be due to care, love, and companionship offered by friends and relatives in family setup. Despite this, elderly in the family setup were more worried and had fears regarding death as compared to OAH residents.

On the contrary, some studies revealed that elderly living in OAH had higher QOL than family setup.[3,11] In our study, we found that there is no statistically significant difference between males and females in all domains of QOL except in the domain social participation similar to a study in Jammu[13] stated that females in family setup had a good QOL may be due to a positive attitude and good social relationship. On the contrary, the study conducted in rural Northern India reported that males had better QOL in the same domain.[14]

We found that 60% of the elderly in OAHs are depressed and have significantly higher GDS scores as compared to those in family setup. In family setup, males are significantly depressed than females, this could be due to females are engaged in household chores, rearing of grandchildren. Similar studies conducted in Hyderabad and Maharashtra[15,16] also revealed that geriatric depression was more in OAHs, ranging from 53.6%–60%. This could be due to loneliness after separation from family, poor health or due to adverse living conditions

Table 2: Quality of life of elderly assessed by World Health Organization Quality of Life-old module and geriatric depression scale

Domains in WHOQOL-old module	Elderly	*n*	Mean	SD	SEM	Mann–Whitney U-test statistic	*Z*	*P*
I: Sensory abilities (old)	Within family	120	75.83	22.468	2.051	3398	−0.618	0.537
	OAHs	60	71.97	26.752	3.454			
II: Autonomy (old)	Within family	120	60.62	17.352	1.584	2736	−2.641	0.008*
	OAHs	60	51.35	20.198	2.608			
III: Past, present and future activities (old)	Within family	120	70.62	17.800	1.625	2787	−2.496	0.013*
	OAHs	60	62.91	21.920	2.830			
IV: Social participation (old)	Within family	120	66.14	14.732	1.345	2927	−2.064	0.039*
	OAHs	60	59.47	17.394	2.246			
V: Death and dying (old)	Within family	120	54.79	15.601	1.424	1973	−4.992	0.001**
	OAHs	60	70.41	20.484	2.644			
VI: Intimacy (old)	Within family	120	58.43	21.432	1.956	2043	−4.574	0.001**
	OAHs	60	41.16	23.210	3.048			
Total transformed scores with 24 items (0-100)	Within family	120	64.41	12.091	1.104	2966	−1.596	0.11
	OAHs	60	59.42	15.608	2.049			
Depression by GDS scale	Within family	120	3.96	4.024	80.42 (mean rank)	2390	−3.693	0.0001
	OAHs	60	5.76	3.406	110.67 (mean rank)			

*Significant at 5% level of significance, **: Significant at 1% level of significance. OAHs: Old age homes, GDS: Geriatric depression scale, SD: Standard deviation, SEM: Standard error mean, WHOQOL: World Health Organization Quality of Life

in the OAHs. The limitation of this study is it covers only one district, further multi-centric studies are required to determine the reason for this difference.

Conclusion

The result of this study showed that the QOL of elderly was better within family setup as compared to elderly in OAHs. Elderly people in OAHs were significantly more depressed than elderly within family setup.

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Conflicts of interest

There are no conflicts of interest.

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